APPLICATION FOR SCL WAIVER AND INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD) SERVICES

Section 1

DO NOT leave any information blank in section 1. Applications will be returned if left blank.

Name - Legibly print first, middle and last name of applicant
Sex - Check whether the applicant is male or female
SS# - Be sure the social security number has 9 numbers
Medical Assistance Number - This is the # on the MEDICAID card (10 numbers)
DOB - example: 08/18/1966
Phone Number - Always include area code. If no phone, please write "no phone"
Current Address - Please print legibly.

Name _____ _____ _____ Sex: ☐M ☐F
(First) (Middle) (Last)
Social Security Number: _____ Medical Assistance Number: _____

Date of Birth _____ Phone #: (_____)_____
(Month, Day, Year)
Current Address _____

_____ _____ _____ _____
(City) (County) (State) (Zip Code)

Section 2

Complete this section only if there is a LEGAL representative or guardian

If the applicant is a minor, there **must** be a legal guardian. If there is a legal guardian, the **signature is REQUIRED**.

Legal Representative/Guardian: _____
Address _____

_____ _____ _____ _____
City County State Zip Code
Phone: _____ Relationship to Applicant: _____
Email: _____ (Ex: mother, father, friend)

Guardian's Signature _____ **Date** _____

2nd Legal Representative/Guardian: _____
Address _____

_____ _____ _____ _____
City County State Zip Code
Phone: _____ Relationship to Applicant: _____
Email: _____ (Ex: mother, father, friend)

Co-Guardian's Signature _____ Date _____

Section 3
Complete this section IF there is a Case Manager

A Case Manager coordinates services. This could be a person or an agency such as the local community mental health center. Leave this section blank if there is no case manager for the applicant.

Case Management Agency: _____
Case Manager Name: _____
Address: _____

_____ City _____ (County) _____ State _____ Zip _____ Phone

Email: _____

Section 4
This section MUST be completely filled out and SIGNED by a physician or SCL Developmental Disability Professional

If you need assistance with this section, contact the community mental health center in your area:
http://www.mhmr.ky.gov/CMHC/

If applying for placement on the SCL waiting list, you **must** attach the results of a psychological examination completed by a licensed psychologist or psychologist with autonomous functioning. The examination must support the ID/DD diagnosis (including IQ score and adaptive behavior assessment).

CMHC DD Director Signature is **NOT** required unless you are applying for ICF/MR (facility) placement.
If applying for ICF/MR placement you **must** attach a copy of applicant's current Plan of Care, current psychological, social history, crisis plan, behavior support plan, a current needs assessment, and minutes from the team meeting recommending ICF/MR admission. The DD director's signature indicates that all community options have been exhausted and an ICF/MR is the least restrictive placement available.

DSM Diagnosis

Axis I – DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis
Axis II - DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis
Axis III - DO NOT LEAVE BLANK - write "none" on the line if there is no diagnosis

Age disability identified is the age the applicant was diagnosed with an intellectual or developmental disability (Ex: birth, 1 yr old, etc.). Intellectual disability must be present prior to age 18. Developmental disability must be present prior to age 22.

DSM Diagnosis:
Axis I (Mental Health): _____
Axis II (Mental Retardation/Developmental Disability) _____
Axis III (Physical Health): _____
Age Disability Identified _____

_____ _____ ☐ SCL Waiver
Physician/SCL DDP Signature Date

_____ _____ ☐ ICF/MR
CMHC DD Director Signature Date

Section 5

The APPLICANT MUST sign this section IF s/he does NOT have a legal guardian.

If unable to sign, a mark (such as "X") is acceptable.

Most of the headings to describe the applicant require checking only the one that best describes the person. Numbers 7, 9, and 10 allow more than one item to be checked.

The person completing the application MUST sign, date, and provide contact information.

Applicant's Signature _____ Date _____

INFORMATION ABOUT THE APPLICANT

1. MOBILITY (Check **ONE**)

☐ Walks independently ☐ Walks with supportive devices ☐ Uses wheelchair operated by self
☐ Uses wheelchair & needs help ☐ Walks unaided with difficulty ☐ No mobility

Comments:

_____

2. COMMUNICATION (Check **ONE**)

☐ Speaks and can be understood ☐ Speaks and is difficult to understand ☐ Uses sign language
☐ Uses communication board or device ☐ Uses gestures ☐ Does not communicate

Comments:

_____

3. HOW MUCH TIME IS REQUIRED FOR ASSURING SAFETY? (Check **ONE**)

☐ Requires less than 8 hours per day on average
☐ Requires 9-16 hours daily on average
☐ Requires 24 hours (does not require awake person overnight)
☐ Requires 24 hours with awake person overnight
☐ **Extreme Need:** Requires 24 hours, awake person trained to meet individual's particular needs; continuous monitoring

Comments

_____

4. HOW MUCH ASSISTANCE IS NEEDED FOR DAILY LIVING TASKS? (Check **ONE**)

☐ **No assistance** needed in **most** self-help and daily living areas, **and minimal assistance** ***(use of verbal prompts or gestures as reminders)*** needed **in some** self-help and daily living **and Minimal to complex assistance** needed to complete complex skills such as financial planning & health planning.
☐ **No assistance** in **some** self-help, daily living areas, **and minimal assistance** for many skills, **and complete assistance (*caregiver completes all parts of task)*** needed in **some** basic skills and all **complex** skills.
☐ **Partial** ***(use of hands on guidance for part of task)*** **to complete assistance** needed **in most** areas of self-help, daily living, and decision making, **and** cannot complete **complex** skills.
☐ **Partial to complete assistance** is needed **in all areas** of self-help, daily living, decision making, and complex skills.
☐ **Extreme Need:** All tasks must be done for the individual, with no participation from the individual.

5. HOW OFTEN ARE DOCTOR VISITS NEEDED? (Check **ONE**)

☐ For routine health care only / once per year
☐ 2-4 times per year for consultation or treatment for chronic health care need
☐ More than 4 times per year for consultation or treatment
☐ **Extreme Need:** Chronic medical condition requires immediate availability and frequent monitoring

6. HOW OFTEN ARE NURSING SERVICES NEEDED? (Check **ONE**)

☐ Not at all ☐ For routine health care only ☐ 1-3 times per month ☐ Weekly ☐ Daily
☐ **Extreme Need:** Several times daily or continuous availability
Comments
_____

7. ARE THERE BEHAVIORAL PROBLEMS? Yes☐ No☐
IF THERE ARE BEHAVIORAL PROBLEMS CHECK ALL THAT APPLY.

☐ Self Injury
☐ Aggressive towards others `
☐ Inappropriate sexual behavior
☐ Life threatening (threat of death or severe injury to self or others)
☐ Property destruction
☐ Takes prescribed medications for behavior control

Comments:
_____:_____

8. WHERE IS THE INDIVIDUAL CURRENTLY LIVING? (Check **ONE**)

☐ Living with family/relative
☐ Group home or personal care home
☐ ICF/MR (Intermediate Care Facility)
☐ Other _____
☐ Living in own home or apartment
☐ Nursing home
☐ Living with a friend
☐ Foster Care
☐ Psychiatric Facility

9. SERVICES THE INDIVIDUAL CURRENTLY RECEIVES (Check **ALL THAT APPLY**)

☐ Acquired Brain Injury
☐ Behavior Support
☐ Case Management
☐ Day Program
☐ EPSDT (if under 21)
☐ Hart Supported Living
☐ Home & Community Based Waiver
☐ Home Health
☐ Mental Health Counseling/Medication
☐ Michelle P Waiver
☐ Occupational Therapy
☐ Physical Therapy
☐ Residential
☐ Respite
☐ School
☐ Speech Therapy
☐ Supported Employment
☐ Other Medicaid Services _____
☐ Other _____

10. SERVICES NEEDED NOW OR IN THE FUTURE? (Check **ALL THAT APPLY**)

☐ Behavior Support
☐ Case Management
☐ Community Access
☐ Day Training
☐ Occupational Therapy
☐ Personal Assistance
☐ Physical Therapy
☐ Residential
☐ Respite
☐ School
☐ Speech Therapy
☐ Supported Employment
☐ Other _____

11. WHERE WOULD THE APPLICANT PREFER TO LIVE IN THE FUTURE? (Check **ONE**)

☐ At home with a family member with someone to come in and help
☐ In the person's own home with supports
☐ In residential services in the community living with a family
☐ In residential services in a community home with staff

12. WHO IS THE PRIMARY CAREGIVER? (If staff is primary caregiver, leave 13 & 14 blank)

☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Staff
☐ Sister ☐ Brother ☐ Friend ☐ Neighbor ☐ Other: Who? _____

13. WHAT IS THE AGE OF THE PRIMARY CAREGIVER?

☐ Less than 30 years old ☐ 31-50 years old ☐ 51-60 years old ☐ 61-70 years old
☐ 71-80 years old ☐ Over 80 years old

14. THE PRIMARY CAREGIVER'S HEALTH STATUS COULD BE CLASSIFIED AS:

☐ Poor ☐ Stable ☐ Good ☐ Very Good

Primary Caregiver Name _____

Primary Caregiver contact information (complete this information if different from guardian)

Address: _____

City (County) State Zip Phone

Email: _____

Comments:

_____

Person Completing Application: _____

Print Name

Relationship to Individual Phone Number Email address

Signature Date

Additional Comments:

_____

Mail or fax to:

The Division of Developmental & Intellectual Disabilities
100 Fair Oaks Lane, 4W-C
Frankfort, Kentucky 40621
Fax: 502-564-8917